Personal Information, Privacy, and Treatment Agreement Form

Title (Mr.,Mrs.,Dr.,etc)_____ Name_____

Home Phone (_____) _____ Work Phone (_____) _____

EMail _____ Cell Phone (_____) _____

Address _____

City _____ State _____ Zip Code_____

Social Security # _____ Mayo Clinic # _____

Occupation _____ Employer _____

Date of Birth _____ Height _____ Weight_____

Personal Contact/Spouse_____ Phone (_____) _____

Occupation _____ Employer _____

Bank Name _____ Bank Address _____

How did you find our office, referred by _____

PRIVACY POLICIES and AFFIRMATION of CONSENT to TREATMENT

I understand that **my personal** and **health information** is **confidential** and **private**, and will only be disclosed to others after I sign a release. A complete copy of my rights and our policies, is available for review, upon request (HIPPA/Office Privacy Policies).

I understand that **I may ask any question I wish**, and that it is better to ask them before treatment begins. I may ask about and understand alternative forms of treatment, and the **potential benefits and risks** of the proposed treatment, including the option of no treatment. I will ask about and understand the likely **outcomes with and without** the proposed treatment, including the possible complications or problems during recuperation.

I agree to provide an accurate and complete medical / personal history - including medications I am taking as well as those to which I am allergic. After accepting treatment, I will follow treatment and post-treatment instructions as explained and directed, to the best of my ability, and will permit the recommended diagnostic procedures, including xrays.

I understand that I may be required to understand and sign additional consent forms for procedures such as, oral surgery, periodontal surgery, and root canal treatment. Treatment may include local anesthetic and in very rare instances patients have had an allergic reaction to the anesthetic, an adverse medication reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the procedure. I understand that the areas where anesthetic is applied may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment.

TURN To The OTHER SIDE Of This Sheet

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I acknowledge that dentistry is not an exact science and that no guarantee or assurance has been given by any one as to the results that may be obtained by my consent to treatment. I authorize the provider, assistants, consultants, or designees to perform such procedures as are necessary, in the exercise of their professional judgment, to remedy my condition and any unforeseen acute conditions which may be revealed during the course of treatment.

OFFICE POLICIES

EACH PATIENT, NOT THE INSURANCE COMPANY, IS RESPONSIBLE FOR PAYMENT OF ALL CHARGES TO HIS/HER ACCOUNT AT THE TIME SERVICES ARE RENDERED.

Missed appointments are very costly for everyone, and thus late cancellations or missed appointments may be assessed a fee. Insurance companies will not reimburse fees for missed appointments.

You will receive monthly statements if your account has a balance due regardless of any claim pending between you and the insurance company. We cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

When payment in full on the day of service is made via cash or check, a 5% discount may be applied. Accounts with balances 30 days past due may have a billing service charge applied each month, along with interest charges of 2/3% per month (8% per annum) applied to the unpaid balance. If you disagree or dispute any or all of your balance, you must write to us within 30 days of receipt of your statement. You must include your name, the dollar amount of the dispute, and a description of your concern. You remain obligated to pay all parts of your balance not in dispute, but you do not have to pay the disputed amount while we are resolving the dispute. Accounts 45 or more days past due may be turned over to collections, with appropriate reporting to credit agencies. You are responsible for all charges and expenses incurred by such collection efforts, including but not limited to, court costs, attorney fees, commissions to collection agents, administrative, office, copies of records, and documentation costs.

You may ask us to assist with or submit your claim information to your insurance. We may charge an administrative fee for providing such assistance. If your insurance company requires diagnostic information and/or doctors explanations we may charge a fee for providing such information. If your account is paid in full and we receive claim payments from your insurance company, you may request an immediate refund of the credit on your account. We will not charge any fees for providing such refunds.

If you desire further information on our policies, please call or ask our office manager. If you desire, we can provide our full policies, in writing.

Under some conditions, we may provide financing if a separate agreement is signed prior to the start of treatment, and with a specific treatment plan defined. This may require additional disclosure and consent.

I certify that I have read and fully understand the terms and words above, and I will abide by and adhere to all requirements set forth in the above terms.

Patient Signature _____ Date _____